

<i>SERFF Tracking Number:</i>	<i>CCGN-126179777</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Life Insurance Company of North America</i>	<i>State Tracking Number:</i>	<i>42587</i>
<i>Company Tracking Number:</i>	<i>09-5003AR</i>		
<i>TOI:</i>	<i>H14G Group Health - Hospital Indemnity</i>	<i>Sub-TOI:</i>	<i>H14G.000 Health - Hospital Indemnity</i>
<i>Product Name:</i>	<i>Group Hospital Indmenity Policy</i>		
<i>Project Name/Number:</i>	<i>Enhanced Hospital Indemnity Benefit/09-5003 AR</i>		

Filing at a Glance

Company: Life Insurance Company of North America

Product Name: Group Hospital Indmenity Policy SERFF Tr Num: CCGN-126179777 State: ArkansasLH

TOI: H14G Group Health - Hospital Indemnity SERFF Status: Closed

State Tr Num: 42587

Sub-TOI: H14G.000 Health - Hospital Indemnity Co Tr Num: 09-5003AR

State Status: Approved-Closed

Filing Type: Form

Co Status:

Reviewer(s): Rosalind Minor

Author: Carolyn Caldwell

Disposition Date: 06/09/2009

Date Submitted: 06/05/2009

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Enhanced Hospital Indemnity Benefit

Status of Filing in Domicile: Not Filed

Project Number: 09-5003 AR

Date Approved in Domicile:

Requested Filing Mode:

Domicile Status Comments: NA

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Small and Large

Overall Rate Impact:

Group Market Type: Employer

Filing Status Changed: 06/09/2009

Explanation for Other Group Market Type:

State Status Changed: 06/09/2009

Deemer Date:

Corresponding Filing Tracking Number: 09-5003AR

Filing Description:

Enclosed are copies of the above captioned forms, intended for use in your jurisdiction, for your review and approval on a general basis. With the exception of the revised Surgical Benefit form XX-604873PO previously approved in your department which now includes a schedule of benefit for review, these forms are new and are not intended to replace any forms currently on file with your Department.

These forms are to be used in conjunction with the Group Hospital Indemnity form XX-604852, et al previously approved

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by your department 05/19/1995. These forms have not been filed in our domiciliary state since Pennsylvania does not require the filing of forms for delivery outside of their state (Title 31, Chapter 38, Section 89.4 (c)).

It is our intention to make this coverage available to the Consumer Driven Benefits Association (by-laws attached), and other eligible groups as defined in your laws. These forms may be issued directly to such groups located in your state. To such groups located in another state but insuring residents of your state, or to an out-of-state policyholder to which a group located in your state or a group including residents of your state may subscribe.

Company and Contact

Filing Contact Information

Carolyn Caldwell, Compliance Operations Analyst	carolyn.caldwell@cigna.com
1601 Chestnut Street	(215) 761-8529 [Phone]
Philadelphia, PA 19192	(215) 761-5609[FAX]

Filing Company Information

Life Insurance Company of North America	CoCode: 65498	State of Domicile: Pennsylvania
1601 Chestnut Street	Group Code: 901	Company Type:
TL16D		
Philadelphia, PA 19192	Group Name:	State ID Number:
(215) 761-8442 ext. [Phone]	FEIN Number: 23-1503749	

Filing Fees

Fee Required?	Yes
Fee Amount:	\$120.00
Retaliatory?	No
Fee Explanation:	Fee calculated based on state's requirement.
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Life Insurance Company of North America	\$120.00	06/05/2009	28402018

<i>SERFF Tracking Number:</i>	<i>CCGN-126179777</i>	<i>State:</i>	<i>Arkansas</i>
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<i>Company Tracking Number:</i>	<i>09-5003AR</i>		
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<i>Product Name:</i>	<i>Group Hospital Indmenity Policy</i>		
<i>Project Name/Number:</i>	<i>Enhanced Hospital Indemnity Benefit/09-5003 AR</i>		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	06/09/2009	06/09/2009

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<i>Project Name/Number:</i>	<i>Enhanced Hospital Indemnity Benefit/09-5003 AR</i>		

Disposition

Disposition Date: 06/09/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: CCGN-126179777 State: Arkansas

Filing Company: Life Insurance Company of North America State Tracking Number: 42587

Company Tracking Number: 09-5003AR

TOI: H14G Group Health - Hospital Indemnity Sub-TOI: H14G.000 Health - Hospital Indemnity

Product Name: Group Hospital Indemnity Policy

Project Name/Number: Enhanced Hospital Indemnity Benefit/09-5003 AR

Item Type	Item Name	Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Filing Letter	Approved-Closed	Yes
Form	Ambulance Benefit	Approved-Closed	Yes
Form	Doctor's Visit	Approved-Closed	Yes
Form	Emergency Room	Approved-Closed	Yes
Form	Additional Exclusion & Limitation	Approved-Closed	Yes
Form	Revised Surgical Benefits	Approved-Closed	Yes
Form	Revised Preventive Care Test Benefit	Approved-Closed	Yes

SERFF Tracking Number: CCGN-126179777 State: Arkansas

Filing Company: Life Insurance Company of North America State Tracking Number: 42587

Company Tracking Number: 09-5003AR

TOI: H14G Group Health - Hospital Indemnity Sub-TOI: H14G.000 Health - Hospital Indemnity

Product Name: Group Hospital Indemnity Policy

Project Name/Number: Enhanced Hospital Indemnity Benefit/09-5003 AR

Form Schedule

Lead Form Number: XX-604877

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	XX-604877	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Ambulance Benefit	Initial			Ambulance Benefit Rider_2.pdf
Approved-Closed	XX-604874	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Doctor's Visit	Initial			Doctor's Visit Benefit_2.pdf
Approved-Closed	XX-604875	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Emergency Room	Initial			Emergency Room_Urgent Care Rider_2.pdf
Approved-Closed	XX-604885A	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Additional Exclusion & Limitation	Initial			HIP Exclusion adds.pdf
Approved-Closed	XX-604873PO	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Revised Surgical Benefits	Initial			Amended_Su rgical Benefits _Policy_.pdf
Approved-Closed	XX-604786	Certificate Amendmen	Revised Preventive Care Test Benefit	Initial			Revised_Prev ent Care Test

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<i>Project Name/Number:</i>	<i>Enhanced Hospital Indemnity Benefit/09-5003 AR</i>		
	t, Insert		Benefit
	Page,		Rider.pdf
	Endorseme		
	nt or Rider		

AMBULANCE BENEFIT

This rider is attached to and made a part of the Group Hospital Indemnity policy. This rider is subject to the terms, conditions, and provisions contained in the policy.

Coverage under this rider begins on the effective date shown on the Policy Schedule, provided premiums are paid when due.

Ambulance Benefits – [Applicable to Covered Persons who are under age 65]]: We will pay [\$200] directly to the Insured or [Insured's Covered Dependent] if the Covered Person requires Medically Necessary ambulance transportation by air or ground, to or from a Hospital. The ambulance services provided must be for transportation: 1) To the nearest Hospital that is able to provide appropriate care; or 2) From the Hospital to a Covered Person's residence or another medical facility that is required for treatment of the Covered person's condition. These benefits are subject to a maximum of [3] transports [per calendar year/per Policy Year/over the most recent 12-month period] per individual [with a family maximum of [5] transports [per calendar year/per Policy Year/over the most recent 12-month period]].

Definitions

"Ambulance" -- means a vehicle that is:

- a) licensed or certified as an emergency vehicle (if required by law);
- b) furnished with life-saving equipment and supplies; and
- c) operated by personnel who are especially trained in emergency care.

"Covered Accident" – means a sudden, unforeseeable, external event that results, directly and independently of all other causes, in a Covered Injury or Covered Loss and meets all of the following conditions:

1. occurs while {the Covered Person} is insured under this Policy;
2. is not contributed to by disease, Sickness, mental or bodily infirmity;
3. [occurs while {the Covered Person} is {variable; e.g., any of the following may be included: attending, participating in, or traveling to and from any event sponsored by {the Policyholder, Subscriber}}];
4. is not otherwise excluded under the terms of this Policy.

"Family "- means the Insured plus all covered immediate family members, a person who is related to the Insured in any of the following ways: Spouse, and child (includes legally adopted child or stepchild).

This rider terminates at the same time as the policy to which it is attached unless terminated at an earlier date. Except for the above, the rider does not change the policy in any way.

LIFE INSURANCE COMPANY OF NORTH AMERICA



Karen Rohan, President

DOCTOR'S VISITS BENEFIT

This rider is attached to and made a part of the Group Hospital Indemnity policy. This rider is subject to the terms, conditions, and provisions contained in the policy. Coverage under this rider begins on the effective date shown on the Policy Schedule, provided premiums are paid when due.

Benefits – [Applicable to Covered Persons who are under age [65]]:

We will pay [\$75.00] directly to the Insured or [Insured's Covered Dependent if [after completion of the applicable Waiting Period] the Covered Person visits a Doctor [as an Outpatient] for other than surgery, due to an Injury [or Sickness]. [Coverage is also provided for newborn well-care and routine health examinations for children aged 5 and under.] These benefits are subject to a maximum of [5] visits [per calendar year/per Policy Year/over the most recent 12-month period] per individual [with a family maximum of [10] visits [per calendar year/per Policy Year/over the most recent 12-month period]].

For a visit due to injuries received in a Covered Accident, the visit must occur within [72] hours after the date of the Covered Accident.

Written proof of loss, should include one or more of the following: bills verifying the patient name, the date of treatment, the diagnosis and the charges incurred.

EXCLUSIONS:

[This benefit is not payable for [routine health examinations or immunizations] [for Covered Persons age [6] and older], [for visits for Mental or Nervous Disorders], or [for visits by a surgeon while Confined to a Hospital].]

Definition

"Covered Accident" – means a sudden, unforeseeable, external event that results, directly and independently of all other causes, in a Covered Injury or Covered Loss and meets all of the following conditions:

1. occurs while {the Covered Person} is insured under this Policy;
2. is not contributed to by disease, Sickness, mental or bodily infirmity;
3. [occurs while {the Covered Person} is {variable; e.g., any of the following may be included: attending, participating in, or traveling to and from any event sponsored by {the Policyholder, Subscriber}}];
4. is not otherwise excluded under the terms of this Policy.

"Family" - means the Insured plus all covered immediate family members, a person who is related to the Insured in any of the following ways: Spouse, and child (includes legally adopted child or stepchild).

This rider terminates at the same time as the policy to which it is attached unless terminated at an earlier date. Except for the above, the rider does not change the policy in any way.

LIFE INSURANCE COMPANY OF NORTH AMERICA



Karen Rohan, President

EMERGENCY ROOM/URGENT CARE BENEFIT

This rider is attached to and made a part of the Group Hospital Indemnity policy. This rider is subject to the terms, conditions, and provisions contained in the policy.

Coverage under this rider begins on the effective date shown on the Policy Schedule, provided premiums are paid when due.

Benefits – [Applicable to Covered Persons who are under age [65]]:

We will pay [\$100] directly to the Insured or [Insured's Covered Dependent] if [after completion of the applicable Waiting Period] the Covered Person requires and incurs charges for Emergency Room [or Urgent Care Facility] services for the Medically Necessary treatment of an Injury or Sickness, to a maximum of [3] visits per individual [per calendar year/per Policy Year/over the most recent 12-month period] [with a family maximum of [10] visits [per calendar year/per Policy Year/over the most recent 12-month period]].

[Services must be rendered by a Doctor including, but not limited to chiropractors, osteopaths, and podiatrists.]

For a visit due to injuries received in a Covered Accident, the visit must occur within [72] hours after the date of the Covered Accident.

Written proof of loss, should include one or more of the following: bills verifying the patient name, the date of treatment, the diagnosis and the charges incurred.

Definitions

"Emergency Room" – means a special area in a Hospital that is equipped and staffed to give people emergency treatment on an out-patient basis. An Emergency Room is not a clinic or a doctor's office.

Urgent Care is medical, surgical, Hospital or related health care services and testing which are not Emergency Services, but which are determined by CG, in accordance with generally accepted medical standards, to have been necessary to treat a condition requiring prompt medical attention. This does not include care that could have been foreseen before leaving the immediate area where you ordinarily receive and/or were scheduled to receive services. Such care includes, but is not limited to, dialysis, scheduled medical treatments or therapy, or care received after a Physician's recommendation that the insured should not travel due to any medical condition.

"Medically Necessary" -- means a treatment, service or supply that is 1) required to treat an injury; 2) prescribed or ordered by a Doctor or furnished by a Hospital; 3) performed in the least costly setting required by the Covered Person's condition; and 4) consistent with the medical and surgical practices prevailing in the area for treatment of the condition at the time rendered. A service or supply may not be Medically Necessary if a less intensive or more appropriate diagnostic or treatment alternative could have been used. We may, at Our discretion, consider the cost of the alternative to be the Covered Expense.

"Medical Emergency" -- means a condition caused by an injury that manifests itself by symptoms of sufficient severity that a prudent lay person possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would place the health of the person in serious jeopardy.

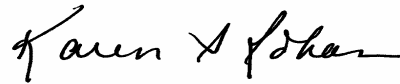
"Covered Accident" – means a sudden, unforeseeable, external event that results, directly and independently of all other causes, in a Covered Injury or Covered Loss and meets all of the following conditions:

1. occurs while {the Covered Person} is insured under this Policy;
2. is not contributed to by disease, Sickness, mental or bodily infirmity;
3. [occurs while {the Covered Person} is {variable; e.g., any of the following may be included: attending, participating in, or traveling to and from any event sponsored by {the Policyholder, Subscriber}}];
4. is not otherwise excluded under the terms of this Policy.

"Family "- means the Insured plus all covered immediate family members, a person who is related to the Insured in any of the following ways: Spouse, and child (includes legally adopted child or stepchild).

This rider terminates at the same time as the policy to which it is attached unless terminated at an earlier date. Except for the above, the rider does not change the policy in any way.

LIFE INSURANCE COMPANY OF NORTH AMERICA

A handwritten signature in black ink, appearing to read "Karen A. Rohan". The signature is fluid and cursive, with a large initial "K" and a stylized "R" at the end.

Karen Rohan, President

Additional Exclusions And Limitations

1. Piloting or serving as a crewmember or riding in any aircraft except as a fare-paying passenger on a regularly scheduled or charter airline.
2. Work related injuries covered under Worker's Compensation, Employer's Liability Laws, or similar occupational benefits
3. Medical mishap or negligence, including malpractice
4. While traveling outside the United States, Canada, Mexico, or any United States possessions, except for a Medical Emergency or a covered Accidental Death or Accidental Dismemberment.
5. Treatment by an Immediate Family member or a member of the Covered Person's household.
6. Alcoholism or drug addiction
7. Hernia, adenoids, tonsils, varicose veins, appendix, disorder of the reproductive organs, voluntary abortion, or elective sterilization with 6 months after the Covered Person's effective date of insurance.
8. Rest care, convalescent care, or rehabilitative care.
9. Injury or death from an Accident where the Covered Person's intoxication would be considered a contributing cause to the Accident. Intoxication is determined according to the laws and/or regulations of the jurisdiction in which the Accident occurred. It will be considered a contributing cause if:
 - An investigation into the cause of the Accident by a police department or other government body makes such determination; or
 - It meets a "prudent and reasonable" test. "Prudent and reasonable" means that a review of the circumstances of the Accident by an ordinarily prudent person would find that the most reasonable interpretation of the facts indicate that intoxication was a causal factor. Much more detailed than our "under the influence exclusion."
10. Loss for which the Covered Person would not be responsible in the absence of this Coverage.

XX-604852-A

SURGICAL BENEFIT

This rider is attached to and made a part of the group policy. This rider is subject to the terms, conditions, and provisions contained in the policy.

Coverage under this rider begins on the effective date shown on the Policy Schedule, provided premiums are paid when due.

If, while coverage under this rider is in force, the Insured or the Insured's Covered Dependent undergoes a medically necessary surgical procedure in a hospital, we will pay an amount equal to the Point Value listed in the Schedule of Operations for such procedure times the Unit Value of [\$5.00] provided:

- a) the surgery is performed as a result of a covered sickness or injury; and
- b) the surgical procedure is performed by a doctor.

If the surgical procedure is not listed in the Schedule of Operations, the amount we pay will be consistent with the amounts we pay for surgical procedures that are listed and which is similar in:

- a) the complexity of the surgical procedure;
- b) the degree of skill required to perform the procedure; and
- c) how long it takes to perform the procedure.

If, during one operation, the Insured or the Insured's Covered Dependent undergoes 2 or more surgical procedures through the same incision, we will pay a benefit only for the procedure with the highest Point Value. If, during one operation, the Insured or the Insured's Covered Dependent undergoes 2 or more surgical procedures through different incisions, we will pay:

- a) the full benefit for the surgical procedure with the highest Point Value; and
- b) 50% of the benefit amount for each of the other surgical procedures.

[PRE-EXISTING CONDITIONS LIMITATION]

Surgical procedures performed during the first [12] months that the Insured or the Insured's Covered Dependent are insured by this rider are not covered if the surgical procedure is performed for the treatment of a pre-existing condition. A pre-existing condition is an injury or sickness for which the Insured or the Insured's Covered Dependent received medical advice, care or treatment during the [12-month] period immediately prior to being covered under this rider.]

[SCHEDULE OF BENEFITS]

Surgical Benefit:

Maximum {\$20,000} {per person}, {per calendar year}]

This rider terminates at the same time as the policy to which it is attached unless terminated at an earlier date. Except for the above, the rider does not change the policy in any way.

LIFE INSURANCE COMPANY OF NORTH AMERICA



Michael W. Bell, President

PREVENTIVE CARE TEST[WELLNESS] BENEFIT

This rider is attached to and made a part of the Group Hospital Indemnity policy. This rider is subject to the terms, conditions, and provisions contained in the policy. Coverage under this rider begins on the effective date shown on the Policy Schedule, provided premiums are paid when due.

BENEFIT

We will pay a [\$50] benefit for a preventive/wellness visit. This benefit is subject to a maximum of [4] visits per [calendar year/policy year/12 month period] per [Covered Insured] [Family].

We will pay this benefit if, while coverage under this rider is in force (and after any applicable waiting period), an Insured or the [Insured's Covered Dependent] incurs charges for [one] or [more] of the preventive/wellness tests/procedures listed below.

- [1. Annual Physical Exam
2. Blood test for triglycerides
3. Bone marrow testing
4. Breast ultrasound
5. CA 15-3 (blood test for breast cancer)
6. CA 125 (blood test for ovarian cancer)
7. CEA (blood test for colon cancer)
8. Chest X-ray
9. Colonoscopy or Virtual Colonoscopy
10. Eye exam performed by a licensed optometrist or ophthalmologist
11. Fasting blood glucose test
12. Flexible sigmoidoscopy
13. Hemoccult stool analysis
14. Mammography
15. PSA (blood test for prostate cancer)
16. Pap smear or Thin Prep Pap Test
17. Serum Protein Electrophoresis (blood test for myeloma)
18. Stress test
19. Thermography

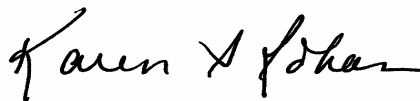
The test must be ordered by a Doctor and Services must be rendered by a Doctor acting within the scope of his license.

Definitions

"Family "- means the Insured plus all covered immediate family members, a person who is related to the Insured in any of the following ways: Spouse, and child (includes legally adopted child or stepchild).

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LIFE INSURANCE COMPANY OF NORTH AMERICA



Karen Rohan, President

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Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number: CCGN-126179777 State: Arkansas
Filing Company: Life Insurance Company of North America State Tracking Number: 42587
Company Tracking Number: 09-5003AR
TOI: H14G Group Health - Hospital Indemnity Sub-TOI: H14G.000 Health - Hospital Indemnity
Product Name: Group Hospital Indemnity Policy
Project Name/Number: Enhanced Hospital Indemnity Benefit/09-5003 AR

Supporting Document Schedules

Review Status:
Satisfied -Name: Flesch Certification Approved-Closed 06/09/2009
Comments:
Attachment:
HIP Flesch Cert.pdf

Review Status:
Satisfied -Name: Application Approved-Closed 06/09/2009
Comments:
The attached policy application was previously approved by your department 05/19/1995
Attachment:
PH application.pdf

Review Status:
Satisfied -Name: Filing Letter Approved-Closed 06/09/2009
Comments:
Attachment:
AR_Filing Letter.pdf

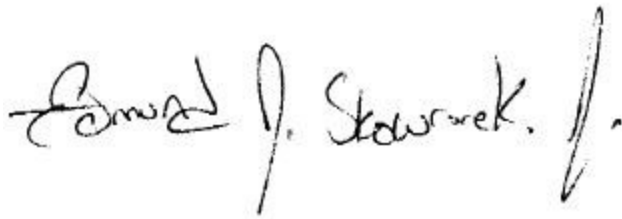
**Life Insurance Company of North America
1601 Chestnut Street
P.O. Box 7716
Philadelphia, PA 19192-2235**

READABILITY CERTIFICATION

We, the Life Insurance Company of North America, certify that we have carefully scored the forms listed below, using the Flesch Readability Test, in accordance with applicable readability standards. Each form was scored separately and in its entirety. These scores are set forth below.

Form Number	Description of Form	Score
XX-604852, et al	Group Hospital Indemnity	51.762

Signature:



Name: Edmund J. Skowronek

Title: Assistant Secretary

Date: May 21, 2009

LIFE INSURANCE COMPANY OF NORTH AMERICA
Philadelphia, Pennsylvania

We, [ABC Company] _____,
whose main office address is [Anytown, Your State] _____ hereby apply to the
Life Insurance Company of North America for Group Policy No. [PCA-200] We approve and accept
the terms of this Group Policy. This application is to be signed in duplicate. One part is to be attached to the
Group Policy; the other part is to be returned to the Life Insurance Company of North America.
This application supersedes any previous application for the Group Policy.

_____[ABC COMPANY]_____
(Full or Corporate Name of Applicant)

Signed at _____ By _____
(Signature and Title)

On _____ Witness _____
(to be signed by Licensed Resident Agent where required by law)

(This Copy Is To Remain Attached To The Policy)

LM-1K59

LIFE INSURANCE COMPANY OF NORTH AMERICA
Philadelphia, Pennsylvania

We, [ABC Company] _____,
whose main office address is [Anytown, Your State] _____ hereby
apply to the Life Insurance Company of North America for Group Policy No. [PCA-200] We approve and
accept the terms of this Group Policy. This application is to be signed in duplicate. One part is to be
attached to the Group Policy; the other part is to be returned to the Life Insurance Company of North
America.
This application supersedes any previous application for the Group Policy.

_____[ABC COMPANY]_____
(Full or Corporate Name of Applicant)

Signed at _____ By _____
(Signature and Title)

On _____ Witness _____
(to be signed by Licensed Resident Agent where required by law)

LM-1K59

Carolyn Caldwell
Compliance Specialist
Product Development & Filing

Group Insurance Division

a

June 5, 2009

ATT: Commissioner Jay Bradford
Arkansas Insurance Department
1200 West 3rd Street
Little Rock, Arkansas

Routing TL16D
1601 Chestnut St.
Philadelphia PA 19192
Telephone 215.761.8529
Facsimile 215.761.5609
Carolyn.Caldwell@cigna.com

RE: Group Hospital Benefits
XX-604852 (Group Hospital Indemnity Policy)
XX-604854 (Group Hospital Indemnity Certificate)
XX-604877 (Ambulance Benefit)
XX-607874 (Doctor's Visit Benefit)
XX-604875 (Emergency Room Urgent Care Benefit)
XX-604852A (Additional Exclusion and Limitation)
XX-604873PO (Surgical Benefit)
XX-604876 (Preventive Carte Benefit)
In and Out-of-state filing
Life Insurance Company of North America NAIC # 65498
09-5003AR/ SERFF Tracking# CCGN-126179777

Dear Commissioner Bradford:

Enclosed are copies of the above captioned forms, intended for use in your jurisdiction, for your review and approval on a general basis. With the exception of the revised Surgical Benefit form XX-604873PO previously approved in your department which now includes a schedule of benefit for review, these forms are new and are not intended to replace any forms currently on file with your Department.

These forms are to be used in conjunction with the Group Hospital Indemnity form XX-604852, et al previously approved by your department 05/19/1995. These forms have not been filed in our domiciliary state since Pennsylvania does not require the filing of forms for delivery outside of their state (Title 31, Chapter 38, Section 89.4 (c)).

It is our intention to make this coverage available to the Consumer Driven Benefits Association (by-laws attached), and other eligible groups as defined in your laws. These forms may be issued directly to such groups located in your state. To such groups located in another state but insuring residents of your state, or to an out-of-state policyholder to which a group located in your state or a group including residents of your state may subscribe.

We appreciate you taking the time to review our forms, and trust that all is in compliant to your law for a prompt approval. If you should have any questions or need additional information, please do not hesitate to e-mail me at Carolyn.Caldwell@cigna.com or call me collect at 215.761.8529.

Very truly yours,



Carolyn Caldwell

Life Insurance Company of North America
Connecticut General Life Insurance Company
CIGNA Life Insurance Company of New York

March 6, 2009
Page 2

Compliance Specialist